Evergreen Medical Group
Providing Individualized Medical Care Since 1996.

PATIENT INFORMATION INTAKE SHEET

Last name	First	Middle	Prefer to be called

Birth date / /	Social Security number	Sex ☐Male ☐Female ☐Transgender

Home phone number ( )	Cell phone number ( )	May we leave discrete messages relating to your visits? ☐Yes ☐No

Street Address	City	State	Zip Code

May we send letters to this address? ☐Yes ☐No	E-Mail address	Mother's first name

What cultural/ethnic group do you identify with? (Please check all that apply)

☐African American/Black ☐Asian/Pacific Islander ☐Hispanic

☐Native American/Alaskan Native ☐White ☐Something Else_____

What languages do you speak?	What languages do you prefer?

Where were you born? City _____ State _____	Do you have a driver's license? ☐Yes ☐No If Yes, what State? _____

Health Insurance Company	Policy number	What hospital do you prefer to use?

What pharmacy do you prefer to use?	Pharmacy phone number	Pharmacy address

Is there another doctor you see regularly? ☐Yes ☐No If Yes, Doctor's Name _____	For Women only: Do you have an OB/GYN? ☐Yes ☐No If Yes, Doctor's Name _____

Do you receive services at any other agency? ☐Yes ☐No	Do you have a case manager? ☐Yes ☐No

In case of emergency, who should we contact?	Relationship	Phone Number

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

X_____ **X** _____

Patient/Guardian Signature Date